CRITERIA FOR MEDICAL AND SURGICAL PROCEDURES

Reference: Medical and Surgical Procedure Codes List and Hospital Surgical Procedures Code List

Table of Contents

Criteria #1 (Laminectomy) . . . 3
Criteria #2 (Spine) . . . 4
Criteria #3 for 62287 and 62292: Aspiration procedure. . . ; Injection procedure of chemonucleolysis) . . . 4
Criteria #4 (Arthroscopy) . . . 5
Criteria #5 (Septoplasty) . . . 5
Criteria #6 (Hiatal or Diaphragmatic Hernia) . . . 5
Criteria #7 (Inguinal Hernias/orchiectomy) . . . 6
Criteria #8 (Orchiectomy) . . . 6
Criteria #9 (Amputation of Penis) . . . 6
Criteria #10 (Sterilization/Other Genito-urinary Procedures) . . . 7
Criteria #11 (Surgical Laparoscopy/Other Medically Necessary Gynecological Procedures) . . . 8
Criteria #12 (Myomectomy) . . . 8
Criteria #13 (Hysteroscopy) . . . 8
Criteria #14 (Abdominal Hysterectomy) . . . 9
Criteria #15 (Vaginal Hysterectomy) . . . 10
Criteria #16 (Emergency Procedures: For Example, Ectopic Pregnancy, Ruptured Uterus) . . . 10
Criteria #17 (Abortion) . . . 11
Criteria #18 (Carpal Tunnel) . . . 12
Criteria #19 (Eye Lid Procedures) . . . 12
Criteria #20 (Contact Lens) . . . 12
Criteria #21 (Hyperbaric Oxygen Therapy) . . . 13
Criteria #24 (Liver Transplants) . . . 14
Criteria #25 (Bone Marrow Transplants) . . . 16
Criteria #26 (Kidney Transplants) . . . 18
Criteria #27 (Cornea Transplants) . . . 19
Criteria #28 (Heart Transplants) . . . 20
Criteria #29 (Lung Transplants) . . . 22
Criteria #30 (Neonatal Care) . . . 24
Criteria #31 (Intestinal Transplantation) . . . 26
Criteria #32: Neurostimulators . . . 28
#32 A: Neurostimulators for Epilepsy . . . 28
#32 B: Sacral Nerve Stimulation . . . 29
#32 C: Spinal Cord Nerve Stimulation . . . 30
Criteria #33A: Trigger Point Injections . . . 32
Criteria #33B: Epidural and Nerve Blocks . . . 33
Criteria #34: Removal of Benign or Premalignant Skin Lesions . . . 35
Criteria #35: Corneal Topography . . . 37
Criteria #36: Urinalysis, Urine Culture . . . 38
Criteria #37: Helicobacter Pylori . . . 39

ALPHABETICAL INDEX OF CRITERIA . . . 40

Criteria for Medical and Surgical Procedures

References:

- Medical and Surgical Procedure Codes List, Utah Medicaid Provider Manual for Physician Services
- Surgical Procedures Code List, Utah Medicaid Provider Manual for Hospital Services

Certain procedure codes identify criteria used by Medicaid staff when reviewing a prior authorization request. Criteria are referenced by number. Use this list in conjunction with the Medical and Surgical Procedure Codes List and Surgical Procedures Code List. Consent requirements for specific procedures (for example, sterilizations and abortions) are included with the criteria.

Criteria #1 (Laminectomy)

CERVICAL: (A, B, and C must be met):

A. One or more of the following must be met:
   1. History of radicular pain (arm, scapula, chest) with or without neck pain.
   2. History of myelopathy (e.g., extremity spasticity, grafted difficulty, bowel and bladder dysfunction, long-tract signs of spinal cord compression). Long-tract signs are: loss of pain sensation, loss of temperature sensation, loss of position sensation, loss of vibratory sensation.
   3. Findings of radiculopathy (e.g., weakness, numbness, reflex change) or myelopathy (hyperflexia, spasticity, positive Babinski)
   4. Dysphagia

B. One or more of the following must be met:
   1. Myelogram, CT scan, or MRI evidence of disk and/or osteophyte impingement of nerve of root or dural sac consistent with history and physical findings.
   2. Dysphagia from osteophytes and/or bulging disk demonstrated radiographically.
   3. Radiographic evidence of:
      a. infection in bone or disk
      b. neoplasm in bone or disk
      c. trauma-induced canal compromise involving bone or disk

C. Failure of non-surgical care (e.g., rest, traction, bracing, (cervical collar), physical therapy, non-steroidal anti-inflammatory drugs, analgesics or muscle relaxants) or documented contraindication to non-surgical care (e.g., intractable pain, significant or progressive neurological deficit).

THORACIC: (A and B must be met):

A. Spinal or nerve root decompression is evidenced by either:
   1. Neurological deficit of both lower extremities. Neurological deficits are: weakness, numbness/tingling, gait disturbance
   2. Radicular pain (pain radiating around chest wall)

B. Myelogram, CT and/or MRI evidence of spinal cord root compression.

LUMBAR/SACRAL: (A, B and C must be met:)

A. One or more of the following must be met:
   1. History of radicular pain with one or more of the following:
      a. Radicular leg pain with or without back pain not sufficiently relieved by conservative care to allow normal life.
      b. Symptoms of cauda equina compression (bowel and bladder dysfunction, saddle anesthesia, bilateral leg pain, weakness, numbness)
   2. Findings of radiculopathy with one or more:
      a. Weakness, numbness, reflex loss in distribution of lumbar root, atrophy of muscle or positive straight leg raising (producing sciatic pain)
      b. Clinical evidence of sacral root compression (e.g., decreased rectal tone, saddle anesthesia).

B. Myelogram, CT scan, MRI evidence of bulging or herniated nucleus pulposus causing nerve root and/or dural impingement, consistent with history and physical findings.

C. Failure of non-surgical care (e.g., rest, traction, bracing, physical therapy, non-steroidal anti-inflammatory drugs, analgesics, or muscle relaxants) or documented contraindication to non-surgical care (e.g., intractable pain, significant or progressive neurological deficit). Non-surgical care is defined as four to six weeks of conservative care.

Criteria #2 (Spine)

A. Approval will be given if one of the following is present:
Radiology report(s) reflect:
1. unstable or potentially unstable fracture
2. disk herniation and/or recurrent herniation at the same level
3. instability secondary to bone tumor, synovitis of rheumatoid arthritis
4. instability or potential instability created by decompression surgery
5. non-union of previous fusion
6. bone spur

B. Approval will be given if two or more of the following are present:
Failure of non-surgical/conservative treatment of four to six weeks duration
1. limited activity or rest
2. traction
3. bracing
4. physical therapy
5. nonsteroidal anti-inflammatory drugs
6. analgesics
7. muscle relaxants

C. Radiology report(s) reflecting:
1. spondylolithiasis
2. spondylolysis
3. segmental instability
4. non-union of previous fusion
5. tumor

Criteria #3 for 62287 and 62292: Aspiration procedure, percutaneous, of nucleus pulposus; Injection procedure of chemonucleolysis

The imaging procedure (CT, MRI) excludes possibility that the disc has been dislocated (hardened) or calcified.

Criteria #4 (Arthroscopy)

One of the following must be present:

A. **Internal derangement** of the joint with **one** of the following present:
   1. significant pain not responding to conservative treatment after 6 weeks
   2. effusion
   3. locking of joint or loss of movement
   4. instability
   5. muscle atrophy

B. Effusion of local or systemic sepsis

C. Intra-articular fracture

D. Suspicion of primary synovial disease

E. Signs and symptoms of impingement syndrome no responding to conservative treatment after 60 days.

Criteria #5 (Septoplasty)

May approve if one or more are present:

A. Nasal airway obstruction if it is associated with obstructive airway disease

B. Nasal airway obstruction if there is an 80% loss of ability to obtain air through nose.

C. Documentation of recurrent sinusitis (three times in six months), unresponsive to conservative treatment. (saline nose drops, humidified air, antibiotics etc).

D. Uncontrollable epistaxis

Criteria #6 (Hiatal or Diaphragmatic Hernia)

Must have endoscopic or radiological evidence of:

A. Distal peptic esophagitis from esophageal reflux in a patient with either:
   1. epigastric anterior pain
   2. retrosternal chest pain

B. Occult bleeding, hernia present, but negative endoscopy results

C. Paraesophageal hernia by x-ray

D. Unresponsive to medical therapy for four weeks with either:
   1. antacids, or
   2. elevation of head and chest at night
   3. bland diet
   4. H2 antagonists

Criteria #7 (Inguinal Hernias/orchiectomy)

A. Must sign sterilization consent (patient must sign if over 20 years of age or parents must sign for a child 20 years of age or younger).
   1. Consent must show patient/parents were informed of the potential sterility that may result from the procedure.
   2. If the procedure is performed for medical reasons (not for voluntary sterilization), the usual 30 day waiting period for a sterilization may be waived.

B. Physical examination reveals existence of groin or inguinal hernia involving the testicle

Criteria #8 (Orchiectomy)

A. Must sign sterilization consent form.

B. Malignant neoplasm of testicle

C. Torsion of testicle causing gangrene

D. Trauma

E. Adjuvant therapy for prostate cancer

Criteria #9 (Amputation of Penis)

A. Must sign sterilization consent form

B. Carcinoma of penis

C. Trauma unresponsive to other measures

D. Sustained priapism (abnormal erection) as in Sickle Cell crisis

E. Peyronie disease, unresponsive to other measures

F. Infection unresponsive to conservative medical treatment

Criteria #10 (Sterilization/Other Genito-urinary Procedures)

A. Client must be 21 years of age at time consent is signed.

B. Client must be mentally competent to sign consent.

C. For a client who is pregnant, the consent must be signed at least 30 days before the expected delivery date. This is true even in the case of the emergency exception explained in paragraph 2 of Form 499-A (Medicaid Sterilization Consent Form) under the heading PHYSICIAN'S STATEMENT.

D. Client must not be in an institution (for example, Utah State Hospital) or correctional facility (for example, Utah State Prison).

E. Procedure must be performed no sooner than 30 days after the client signs the consent and no longer than 180 days, unless it meets the requirements in paragraph 2 of Form 499-A (Medicaid Sterilization Consent Form) under the heading PHYSICIAN'S STATEMENT.

F. Signed sterilization consent must be witnessed and dated by a physician or nurse.

Note: If the procedure is performed for medical reasons, other than voluntary sterilization, the usual 30 day waiting period for sterilization may be waived.

Criteria #11 (Surgical Laparoscopy/Other Medically Necessary Gynecological Procedures)

A. Must sign sterilization consent (patient must sign if over 20 years of age or parents must sign for a child 20 years of age or younger).

B. Carcinoma

C. Ovarian pregnancy
   1. tissue should include products of conception.

D. Adnexal torsion
   1. abrupt onset of lower abdominal pain
   2. nausea and vomiting
   3. low grade fever of at least 100* F
   4. tender mass may be palpable

E. Cyst* or solid benign ovarian tumor
   1. serous cystadenoma (depending on size)
   2. mucous cystadenoma
   3. benign or malignant (dermoid cyst)

   Cyst* must meet one of the following:
   (1) Cyst greater than 6 cm demonstrated by ultra sound for more than one menstrual cycle on birth Control Pills.
   (2) Solid ovarian tumor demonstrated by ultra sound
   (3) Complex ovarian cyst demonstrated by ultra sound

   Note: Corpus luteum cyst is a normal physiologic finding and does not meet criteria

Criteria #12 (Myomectomy)

This cannot be approved for cases of infertility. If patient is pregnant, pregnancy must be preferred over the need for removal of uterine fibroids.

Criteria #13 (Hysteroscopy)

A. Must have at least one of the following:
   1. Need to determine the source of abnormal uterine bleeding
   2. A suspicion of malignancy not otherwise diagnosed
   3. Need to determine the extent of malignancy

B. May not have:
   1. pelvic inflammatory disease
   2. infertility unless post-menopausal

Criteria #14 (Abdominal Hysterectomy)

Approve for the following:

A. Atypical adenomatous hyperplasia

B. Endometrial adenocarcinoma or uterine sarcoma

C. Ovarian malignancy

D. Uterine fibroid with one of the following:
   1. Patient symptomatic-including abnormal uterine bleeding
   2. ureteral obstruction on IVP
   3. rapid enlargement premenopausal
   4. post-menopausal enlargement and benign endometrial sample
   5. Uterus greater than 12 weeks in size on physical exam

E. Recurrent or persistent uterine bleeding with severe dysmenorrhea; unresponsive to D&C and/or hormonal therapy. Abnormal uterine bleeding characterized by one of the following:
   1. Requiring more than seven pads per day.
   2. Over seven days duration.
   3. Occurring more frequently than every 21 days.
   4. Intermenstrual bleeding/non ovulating.
   5. Iron deficiency anemia hemoglobin less than 10.

F. Clinical diagnosis of moderate to severe endometriosis.
   1. Confirmed by diagnostic testing such as laparotomy or laparoscopy within the last year.

G. Consent for medically necessary hysterectomy/sterilization must be signed. Refer to the attachment Hysterectomy Information and Consent.

Criteria #15 (Vaginal Hysterectomy)

Approve one of the following:

A. Recurrent abnormal uterine bleeding characterized by one of the following:
   1. requiring more than 7 pads per day
   2. over 7 days duration
   3. occurring more frequently than every 21 days
   4. intermenstrual bleeding/nonovulating
   5. iron deficiency anemia hemoglobin less than 10

B. In conjunction with vaginal repair of cystocele, rectocele or enterocele that is symptomatic

C. Uterine descensus that is symptomatic

D. Dysmenorrhea with/without abnormal uterine bleeding after diagnostic workup

E. Fibroid uterus greater than 12 weeks size

F. Adenomyosis

G. Recurrent cervical dysplasia with pap smear describing cells

H. Carcinoma-in-situ of cervix (CIN III)

I. If client has a psychiatric diagnosis, a psychiatric evaluation documenting the "patient is capable of informed consent" must be submitted before prior authorization may be given.

J. Consent for medically necessary hysterectomy/sterilization must be signed. Refer to the attachment Hysterectomy Information and Consent.

Criteria #16 (Emergency Procedures: For Example, Ectopic Pregnancy, Ruptured Uterus)

Procedures which ordinarily require prior authorization and consent, but are performed under emergency circumstances, may be authorized "after-the-fact". Documentation to be submitted must include:

A. Completed Prior Authorization Request form

B. Consent form (abortion, sterilization, hysterectomy)

C. Documentation from medical records support the emergent nature of the procedure

D. History and physical

E. Operative report

F. Pathology report

G. Discharge summary

Criteria #17 (Abortion)

Approve only with supporting documentation in the two circumstances listed below:

I. Life of the mother would be endangered from a physical disorder, physical injury, or physical illness, including a life-endangering physical condition caused by or arising from the pregnancy itself, that would, as certified by a physician(s), place the woman in danger of death unless an abortion is performed.

A. Signed abortion consent MUST include:
1. Name and address of Medicaid client.
2. Name and address of obstetrician/gynecologist.
3. Name and address of family physician or internist

Refer to the attachment Informed Consent to Therapeutic Abortion.

B. Documentation submitted with the Prior authorization request **must** include the abortion consent and two letters indicating:
1. Medical judgement of OB/GYN as to why the mother's life is at risk if pregnancy is carried to term.
2. Medical judgement of family physician or internist as to why the mother's life is at risk if pregnancy is carried to term.

Note: Please note the required emphasis on physical disorder, injury or illness.

C. If a psychiatric diagnosis is present, or psychiatric medications are listed, a psychiatric evaluation must be submitted detailing the indication for the medication and certifying, in writing, that the client is capable of making an informed decision.

D. The documentation submitted will be reviewed by a nurse reviewer and two Medicaid physician consultants. BOTH must give their approval for the procedure to be authorized.

II In the case of rape or incest, conditions are:

A. Pregnancy must be less than 24 weeks gestation.

B. Signed abortion consent must include:
1. Name and address of Medicaid client
2. Name and address of obstetrician/gynecologist

Refer to the attachment Informed Consent to Therapeutic Abortion.

C. Documentation submitted with the prior authorization request MUST include:
1. The completed abortion consent; and
2. A statement as to whether or not the incident has been reported to law enforcement agencies. Supporting documentation is desired, but may be waived with a written certification statement from the treating physician that in his professional opinion the patient was unable, for physical or psychological reasons, to comply with the reporting requirements.

C. If a psychiatric diagnosis is present, or psychiatric medications are indicated, a psychiatric evaluation must also be submitted detailing the indication for the medication and certifying, in writing, that the client is capable of making an informed decision.

D. The documentation submitted will be reviewed by a nurse reviewer and medical consultants.

Criteria #18 (Carpal Tunnel)

All of the following must be present:

A. History of **one** or more:
   1. Persistent pain and/or paraesthesia involving only the thumb, index, middle and ring fingers of affected hand
   2. Progressive hand weakness and sensory lost.

B. Findings of **two** or more of the following:
   1. Positive Phalen test.
   2. Positive Tinel sign.
   3. Tenderness and swelling over the palmar aspect of the wrist.
   4. Weakness of muscles in the median nerve distribution.
   5. Atrophy of the thenar eminence (the fleshy mass on the palm of the hand at the base of the thumb)
   6. Abnormal distal median nerve EMG
   7. Abnormal distal median nerve conduction study

C. Failure to respond to conservative therapy or documentation justifying early surgical intervention. Conservative therapy means 4 - 6 weeks splinting, nonsteroidal anti-inflammatory drugs, avoidance of precipitating trauma.

Criteria #19 (Eye Lid Procedures)

Approval will be given for the following:

A. Congenital defect
   1. ptosis
   2. coloboma

B. Trauma

C. Corneal or conjunctival exposure or trichiasis

D. Functional defect:
   1. baggy eyelid that interferes with the patient's vision
   2. Submit a recent photograph of the patient
   3. vision field report

Criteria #20 (Contact Lens)

Contact lenses will be supplied under the Utah Medicaid program **only** for the following conditions: Aphakia, nystagmus, keratoconus, severe corneal distortion and those cases where the visual acuity cannot be corrected to 20/70 in the better eye or when there is very high refractive error, such as in the case of progressive myopia with refractive power going from -10.00 to -11.00 in 2 years.

Contact lenses will not be approved for moderate visual improvement and/or cosmetic purposes.

Oxygen porous contact lenses are not a Medicaid benefit unless a specific medical need exists which precludes glasses and/or hard contact lenses.

Criteria #21 (Hyperbaric Oxygen Therapy)

Must be provided in an approved chamber.

A. Only approved by Medicaid for the following conditions:
   1. acute carbon monoxide intoxication
   2. decompression illness
   3. gas embolism
   4. gas gangrene
   5. acute traumatic peripheral ischemia
   6. crush injuries and suturing of severed limbs
   7. progressive necrotizing infections
   8. acute peripheral arterial insufficiency
   9. preparation and preservation of compromised skin grafts
   10. chronic refractory osteomyelitis unresponsive to conventional medical and surgical management
   11. osteoradionecrosis as an adjunct to conventional treatment
   12. soft tissue radionecrosis as an adjunct to conventional treatment
   13. cyanide poisoning
   14. actinomycosis, only as an adjunct to conventional therapy when the disease process is refractory to antibiotic and surgical treatment.

B. Physician Supervision Requirement: The physician must be in constant attendance during the entire treatment. This is a professional activity that cannot be delegated because it requires independent medical judgement by the physician. Constant monitoring and immediate availability of the physician is essential in all settings for all procedures.

Criteria #24 (Liver Transplants)

A. Liver transplantation services may be provided for a Medicaid eligible client of any age who meets the criteria.

B. All indications for liver transplantation listed below must be met by each client.
   1. The client must have irreversible, progressive liver disease with a life expectancy of one year or less and with no available reasonable alternative medical or surgical therapy.
   2. A current published medical literature review must document a probability of successful clinical outcome by having a greater than or equal to 75 percent one-year survival rate for patients receiving liver transplantation for the specific diagnosis, condition, and age of the client and type of liver transplantation.
   3. All clients must have one of the diagnoses listed below:
      a. End stage liver disease;
         (1) Primary biliary cirrhosis;
         (2) Post-hepatitis(chronic active hepatitis) which is hepatitis B surface antigen negative;
         (3) Cryptogenic cirrhosis;
         (4) Alcoholic cirrhosis;
         (5) Polycystic liver failure.
      b. Acute fulminant liver failure;
      c. Inborn errors of metabolism or other genetic defects;
      d. Biliary atresia;
      e. Primary sclerosing cholangitis;
      f. Budd-chiari Syndrome(congenital hepatic vein thrombosis) or acquired hepatic vein thrombosis;
      g. Pediatric hepatoblastoma and fibrolamellar carcinoma.
   4. Medical assessment that the client is a reasonable risk for surgery with a likelihood of tolerance for immunosuppressive therapy.
   5. Medical assessment by the client's referring physician that the client has sufficient mental, emotional and social stability and support to ensure that he and his parent(s) or guardian(s) will strictly adhere to the long term follow up and the immunosuppressive program which is required.
   6. Psycho-social assessment by a board certified psychiatrist that the client has sufficient mental, emotional, and social stability and support to ensure that he and his parent(s) or guardian(s) will strictly adhere to the long-term follow-up and the immunosuppressive program which is required.
   7. The client must have a strong motivation to undergo the procedure as documented by the medical and psycho-social assessment.
   8. A client with a history of substance abuse must successfully complete a substance abuse rehabilitation program or must have documented abstinence for a period of at least six months before the transplantation can be prior authorized.

C. Any single contraindication listed below shall preclude approval for Medicaid payment for liver transplantation:
   1. Active infection outside the hepatobiliary system.
   2. Acute severe hemodynamic compromise at the time of transplantation, if accompanied by significant compromise of one or more non-hepatic vital end-organs.
   3. Active peptic ulcer.
   4. Hepatitis B surface antigen positive.
   5. Stage IV hepatic coma.
   6. Active substance abuse.
   7. Presence of systemic dysfunction or malignant disease which could limit survival, interfere with compliance with a disciplined medical regiment or rehabilitation after transplantation.
   8. Morbid obesity.

9. Human Immunodeficiency Virus(HIV) antibody positive.
10. Irreversible musculoskeletal disease resulting in progressive weakness or in confinement to bed.
11. Neuropsychiatric disorder which could lead to non-compliance or inhibit rehabilitation for the patient.
12. Pulmonary diseases:
    a. Cystic fibrosis;
    b. Obstructive pulmonary disease (FEV1 <50% of predictable).
    c. Restrictive pulmonary disease (FVC <50% of predictable);
    d. Unresolved pulmonary roentgenographic abnormalities of unclear etiology;
    e. Recent or unresolved pulmonary infarction.
13. Cancer, unless treated and eradicated for two or more years; except for pediatric hepatoblastoma and fibrolamellar carcinoma if there is a high probability of cure with the transplant.
14. Uncorrectable major system congenital anomalies except sight and hearing.
15. Cardiovascular diseases:
    a. Myocardial infarction within six months;
    b. Intractable cardiac arrhythmias;
    c. Class III or IV cardiac dysfunction by New York Heart Association criteria.
    d. Prior congestive heart failure, unless a cardiovascular consultant determines adequate cardiac reserve.
    e. Symptomatic or occlusive peripheral vascular or cerebrovascular disease;
    f. Severe generalized arteriosclerosis.
16. Behavior pattern documented in the client's medical or psycho-social assessment which could interfere with a disciplined medical regimen. A trend of non-compliance by the client is documented by any one of the following:
    a. Non-compliance with medications or therapy;
    b. Failure to keep scheduled appointments;
    c. Leaving the hospital against medical advice.
17. A trend of non-compliance demonstrated by the parent(s) or guardian(s) of the child under 18 years of age by documentation of any of the behaviors listed in 16.a. through c.
18. Evidence of other major organ system disease or anomaly which could decrease the probability of successful clinical outcome or decrease the potential for rehabilitation.
19. The need for prior transplantation of a second organ, such as lung, heart, kidney, or bone marrow, if this represents the coexistence of significant disease.
20. Significant probability that the underlying original hepatic disease will recur, limit survival, or cause disability.

Criteria #25 (Bone Marrow Transplants)

A. Bone marrow transplantation services may be provided for a Medicaid eligible client of any age who meets the criteria.

B. The client for bone marrow transplantation must meet requirements of either section 1 or 2 below:

1. Allogenic and syngeneic bone marrow transplantations will be approved for payment only when the client has an HLA-matched donor. The donor must be compatible for all or a five-out-of-six match of World Health Organization recognized HLA-A, -B, and -DR antigens as determined by appropriate serologic typing methodology. The donor's and recipient's leukocytes must also be non-reactive in a mixed-lymphocyte culture. A current published medical literature review must document a maximum probability of successful clinical outcome by having a greater than or equal to 75 percent one-year survival rate, or by having a greater than or equal to 55 percent three-year survival rate for patients receiving bone marrow transplantation for the specific diagnosis, condition, and age of the client. All clients for allogenic or syngeneic bone marrow transplantation must have one of the following diagnosis:
    a. Acute leukemia in first or second remission;
    b. Chronic myelogenous leukemia in chronic phase;
    c. Myelodysplasia;
    d. Neuroblastoma stage III or IV in children over one year of age;
    e. Severe aplastic anemia diagnoses in the patient who has received less than or equal to 10 units of blood or platelets or both;
    f. Other genetic defects and diseases for which bone marrow transplantation is documented in published medical literature as successful including but not limited to:
        (1) Severe combined immunodeficiency disease;
        (2) Wiskott-Aldrich syndrome;
        (3) Inborn errors of metabolism.

2. Autologous bone marrow transplantations performed in conjunction with total body radiation or high dose chemotherapy, or both, may be covered if a current published medical literature review documents a maximum probability of successful clinical outcome by having a greater than or equal to 75 percent one-year survival rate, or by having a greater than or equal to 55 percent three-year survival rate for patients receiving bone marrow transplantation for the specific diagnosis, condition, and age of the client. All clients for autologous bone marrow transplantations must have adequate marrow function and no evidence of marrow involvement by the primary malignancy at the time the marrow is harvested for the diagnoses listed below:
    a. Acute leukemia in first or second remission;
    b. High or intermediate grade lymphoma after failure of standard chemotherapy;
    c. Neuroblastoma, stage III or IV.

C. In addition to meeting one of the requirements listed above in sections 1 or 2, the client must meet all of the following requirements:

1. The client must have irreversible, progressive disease with a life expectancy of one year or less without transplantation or must have greater than a five year increase in life expectancy with transplantation, or both, with no other reasonable medical or surgical alternative to transplantation available.
2. Medical assessment that the client is a reasonable risk for surgery with a likelihood of tolerance for immunosuppressive therapy;
3. Medical assessment by the client's referring physician that the client has sufficient mental, emotional and social stability and support to ensure that he and his parent(s) or guardian(s) will strictly adhere to the long-term follow-up and the immunosuppressive program;

4. Psycho-social assessment by a board certified psychiatrist that the client has sufficient mental, emotional and social stability and support to ensure that he and his parent(s)s or guardian(s) will strictly adhere to the long-term follow-up and the immunosuppressive program which is required.
5. The client must have a strong motivation to undergo the procedure as documented by the medical and psycho-social assessment;
6. A client with a history of substance abuse must successfully complete a substance abuse program or must have documented abstinence for a period of at least six months before the transplantation service can be authorized.

D. Any single contraindication listed below shall preclude approval for Medicaid payment for bone marrow transplantation:
   1. Active infection.
   2. Acute severe hemodynamic compromise at the time of transplantation if accompanied by significant compromise of on or more vital end-organs.
   3. Active peptic ulcer.
   4. Active substance abuse.
   5. Presence of systemic dysfunction or malignant disease which could limit successful clinical outcome or interfere with compliance with a disciplined medical regiment or rehabilitation after transplantation.
   6. Human Immunodeficiency Virus(HIV) antibody positive.
   7. Irreversible musculoskeletal disease resulting in progressive weakness or in confinement to bed.
   8. Neuropsychiatric disorder which could lead to non-compliance or inhibit rehabilitation of the patient.
   9. Pulmonary diseases:
      a. Cystic fibrosis;
      b. Obstructive pulmonary disease (FEV1 <50% of predictable);
      c. Restrictive pulmonary disease (FVC <50% of predictable);
      d. Unresolved pulmonary roentgenographic abnormalities of unclear etiology;
      e. Recent or unresolved pulmonary infarction.
   10. Morbid obesity.
   11. For consideration of bone marrow transplant approval when the malignancy is not listed in item B of this criterion, the malignancy must have been treated and eradicated for two or more years.
   12. Uncorrectable major system congenital anomalies except sight and hearing.
   13. Cardiovascular diseases:
      a. Symptomatic or occlusive peripheral vascular or cerebrovascular disease;
      b. Severe generalized arteriosclerosis.
   14. Behavior pattern documented in the client's medical or psycho-social assessment which could interfere with a disciplined medical regimen. A trend of non-compliance by the client is documented by any one of the following:
      a. Non-compliance with medications or therapy;
      b. Failure to keep scheduled appointments;
      c. Leaving the hospital against medical advice.
   15. A trend of non-compliance demonstrated by parent(s) or guardian(s) of the client who is under 18 years of age. Non-compliance is demonstrated by documentation of any of the behaviors listed in section D. 14., a through c.
   16. Evidence of other major organ system disease or anomaly which could decrease the probability of successful clinical outcome or decrease the potential for rehabilitation.
   17. The need for prior transplantation of a second organ, such as lung, hear, kidney or liver, if this represents the coexistence of significant disease.

Criteria #26 (Kidney Transplants)

A. Kidney transplantation services may be provided for a Medicaid eligible client of any age who meets all of the following criteria.
   1. The client must have irreversible, progressive end-stage renal disease;
   2. A current published medical literature review must document the probability of successful clinical outcome by having a greater than or equal to 75 percent one-year survival rate for graft function and by having a greater than or equal to 90 percent one-year survival rate for patients receiving renal transplantation for the specific diagnosis, condition and age of the client;
   3. Medical assessment that the client is a reasonable risk for surgery with a likelihood of tolerance for immunosuppressive therapy;
   4. Medical assessment by the client's referring physician that the client has sufficient mental, emotional and social stability and support to ensure that he and his parent(s) or guardian(s) will strictly adhere to the long-term follow-up and the immunosuppressive program which is required;
   5. Psycho-social assessment by a board certified psychiatrist that the client has sufficient, mental, emotional and social stability and support to ensure that he and his parent(s) or guardian(s) will strictly adhere to the long-term follow-up and the immunosuppressive program which is required;
   6. The client must have strong motivation to undergo the procedure as documented by the medical and psycho-social assessment;
   7. A client with a history of substance abuse must successfully complete a substance abuse program or must have documented abstinence for a period of at least six months before the transplantation can be prior authorized.

B. Any single contraindication listed below shall preclude approval for Medicaid payment for kidney transplantation:
   1. Active infection;
   2. Acute severe hemodynamic compromise at the time of transplantation if accompanied by significant compromise of one or more non-renal end-organs;
   3. Active peptic ulcer disease;
   4. Active substance abuse;
   5. Presence of systemic dysfunction or malignant disease which could limit successful clinical outcome, interfere with compliance with a disciplined medical regimen or rehabilitation after transplantation;
   6. Morbid obesity;
   7. Human Immunodeficiency Virus(HIV) antibody positive;
   8. Irreversible musculoskeletal disease resulting in progressive weakness or in confinement to bed;
   9. Neuropsychiatric disorder which could lead to non-compliance or inhibit rehabilitation of the patient;
   10. Pulmonary diseases:
      a. Cystic fibrosis;
      b. Obstructive pulmonary disease(FEV1 <50% of predictable);
      c. Restrictive pulmonary disease(FVC <50% of predictable);
      d. Unresolved pulmonary roentgenographic abnormalities of unclear etiology;
      e. Recent pulmonary infarction.
   11. Cancer, unless treated and eradicated for two or more years.
   12. Uncorrectable major system congenital anomalies except sigh and hearing.
   13. Cardiovascular diseases:
      a. Myocardialinfarction within six months;
      b. Intractable cardiac arrhythmias;
      c. Symptomatic or occlusive peripheral vascular or cerebrovascular disease;
      d. Severe generalized arteriosclerosis.

14. The need for prior transplantation of a second organ, such as lung, heart, liver or bone marrow, if this represents the coexistence of significant disease.
15. Behavior pattern documented in the client's medical or psycho-social assessment which could interfere with a disciplined medical regimen. A trend of on-compliance by the client is documented by any one of the following:
    a. Non-compliance with medications or therapy;
    b. Difficulty keeping scheduled appointments;
    c. Leaving the hospital against medical advice.
16. A trend of non-compliance demonstrated by the parent(s) or guardian(s) of the child under 18 years of age by documentation of any of the behaviors listed in 15.a. through c.
17. Evidence of other major organ system disease or anomaly which could decrease the probability of successful clinical outcome or decrease the potential for rehabilitation.

Criteria #27 (Cornea Transplants)

As of October 29, 1996, corneal transplantation no longer requires prior authorization by Medicaid.

Criteria #28 (Heart Transplants)

A. Heart transplantation services may be provided for a Medicaid eligible client of any age who meets the criteria.
   1. The client must have irreversible, progressive heart disease, with a life expectancy of one year or less, or documented evidence of progressive pulmonary hypertension, or both, and with no available reasonable alternative medical or surgical therapy;
   2. A current published medical literature review must document the probability of successful clinical outcome by having a greater than or equal to 85 percent one-year survival rate for diagnosis, condition and age of the client;
   3. Severe, New York Heart Association Class IV, cardiac dysfunction;
   4. Medical assessment by the client's referring physician that the client is a reasonable risk for surgery with a likelihood of tolerance for immunosuppressive therapy;
   5. Medical assessment by the client's referring physician that the client has sufficient mental, emotional and social stability and support to ensure that he and his parent(s) or guardian(s) will strictly adhere to the long-term follow-up and the immunosuppressive program which is required;
   6. Psycho-social assessment by a board certified psychiatrist that the client has sufficient mental, emotional and social stability and support to ensure that he and his parent(s) or guardian(s) will strictly adhere to thelong-term follow-up and the immunosuppressive program which is required;
   7. The client must have strong motivation to undergo the procedure, as documented by the medical and psycho-social assessment;
   8. A client with a history of substance abuse must successfully complete a substance abuse program or must have documented abstinence for a period of at least six months before the transplantation service can be authorized.

B. Any single contraindication listed below shall preclude approval for Medicaid payment for heart transplantation:
   1. Active infection;
   2. Acute severe hemodynamic compromise at the time of transplantation if accompanied by significant compromise of one or more non-cardiac vital end-organs;
   3. Active peptic ulcer;
   4. Active substance abuse;
   5. Presence of systemic dysfunction or malignant disease which could limit successful clinical outcome, interfere with compliance with a disciplined medical regimen, or rehabilitation after transplantation;
   6. Morbid obesity;
   7. Human Immunodeficiency Virus(HIV) antibody positive;
   8. Irreversible musculoskeletal disease resulting in progressive weakness or in confinement to bed;
   9. Neuropsychiatric disorder which could lead to non-compliance or inhibit rehabilitation of the patient;
   10. Pulmonary diseases:
      a. Cystic fibrosis;
      b. Obstructive pulmonary disease (FEV1 <50% of predictable);
      c. Restrictive pulmonary disease (FVC <50% of predictable);
      d. Unresolved pulmonary roentgenographic abnormalities of unclear etiology;
      e. Recent or unresolved pulmonary infarction.
   11. Cancer, unless treated and eradicated for two or more years.
   12. Uncorrectable major system congenital anomalies except sigh and hearing.
   13. Cardiovascular diseases:
      a. Severe pulmonary hypertension documented in patients 18 years of age and older by a pulmonary vascular resistance greater than 8 Wood units, or pulmonary vascular resistance of 6 or 7 Wood units in which a nitroprusside infusion is unable to reduce the pulmonary vascular resistance to less than 3 Wood units or is unable to reduce the pulmonary artery systolic pressure to below 50 mmHg;

b. Severe pulmonary hypertension documented in patients less than 18 years of age by a pulmonary vascular resistance greater than 6 pulmonary vascular resistance index units (PVRI), or in which a nitroprusside infusion is unable to reduce the pulmonary vascular resistance to less than 6 PVRI;

c. Symptomatic or occlusive peripheral vascular or cerebrovascular disease;

d. Severe generalized arteriosclerosis.

14. Behavior pattern documented in the client's medical or psycho-social assessment which could interfere with a disciplined medical regimen. A trend of non-compliance by the client documented by one or more of the following:
    a. Non-compliance with medications or therapy;
    b. Difficulty keeping scheduled appointments;
    c. Leaving the hospital against medical advice.
15. A trend of non-compliance demonstrated by parent(s) or guardian(s) of the child under 18 years of age by documentation of any of the behaviors listed in 14.a. through c.
16. Evidence of other major organ system disease or anomaly which could decrease the probability of successful clinical outcome or decrease the potential for rehabilitation.
17. The need for prior transplantation of a second organ, such as lung, liver, kidney, or bone marrow, if this represents the coexistence of significant disease.

C. Ventricular Assist Device Criteria

1. The patient must meet eligibility conditions as stated in Criteria #28–Heart Transplants.
2. The FDA approved implantable ventricular assist device system is covered strictly as a bridge to transplant for end-stage heart failure.
3. When used in accordance with FDA approved labeling, the patient must be at least eighteen years old, an approved transplant candidate with non-reversible left ventricular failure, and require the device as temporary mechanical circulatory support.
4. Since coverage of this device is limited to use as a bridge to transplant, centers implanting such a device must make every reasonable effort to transplant patients on such devices as soon as practicable and not maintain such patients on this device if a suitable heart becomes available for transplantation.
5. The patient must have reached a state where conservative medical treatments such as vasopressor support are no longer effective and they must be in imminent risk of dying before a donor heart is procured. In addition, all of the following conditions must be met:
6. Where feasible, the patient is on an intraortic balloon pump with optimal inotropic support
7. The patient has severe congestive failure with a left atrial or pulmonary wedge pressure > 20mmHg with either a cardiac index of <2.0 L/min/m2 or a systolic blood pressure <80 mmHg or other measures of patient condition indicate to Medicaid medical staff that the device is required.

Criteria #29 (Lung Transplants)

A. Lung transplantation services may be provided for a Medicaid eligible client of any age who meets the criteria.

B. The client for lung transplantation must meet requirements of at least section B 1 or 2.
   1. The client must have end stage lung disease, with a life expectancy of one year or less, and with no other reasonable medical or surgical alternative to transplantation available.
   2. The transplant center staff must complete, and submit to the Department for staff review and evaluation, a medical literature review, specific to the client's diagnosis and condition, documenting that the condition will cause irreversible, progressive disease to vital end-organs within two years following the application for transplant and have no other reasonable medical or surgical alternative to transplantation available. The medical literature must also document that the lung transplantation will prevent the irreversible, progressive disease to the client's vital end-organs and must document that it will increase the life expectancy of the client by greater than five years. The Department shall use independent research by staff medical consultants to evaluate the documentation submitted by the transplant center.

C. In addition to meeting the requirements listed in section B, the client must meet all of the following requirements:
   1. The transplant center staff must complete, and submit to the Department for staff review and evaluation, a current medical literature review, documenting a probability of successful clinical outcome by having a greater than or equal to 75 percent one-year survival rate for patients receiving lung transplantation for the age group, specific diagnosis(es), and type of transplantation proposed for the client. The Department shall use independent research by staff medical consultants to evaluate the documentation submitted by the transplant center.
   2. Medical assessment that the client is a reasonable risk for surgery with a likelihood of tolerance for immunosuppressive therapy.
   3. Medical assessment by the client's referring physician that the client has sufficient mental, emotional and social stability and support to ensure that the client and parent(s) or guardian(s) will strictly adhere to the long term follow up and the immunosuppressive program which is required.
   4. Psycho-social assessment by a board-certified or board-eligible psychiatrist that the client has sufficient mental, emotional, and social stability and support to ensure that the client and parent(s) or guardian(s) will strictly adhere to the long-term follow-up and the immunosuppressive program which is required.
   5. The client must have a strong motivation to undergo the procedure as documented by the medical and psycho-social assessment.
   6. The client with a history of substance abuse must successfully complete a substance abuse rehabilitation program or must have documented abstinence for a period of at least six months before the Department reviews a request for transplantation services.
   7. A current medical literature review, completed by the transplant center staff and submitted to the Department for staff review and evaluation, documenting that the underlying original lung disease will not recur and limit survival to less than 75% one-year survival rate. The Department shall use independent research by staff medical consultants to evaluate the documentation submitted by the transplant center.

D. Any single contraindication listed below shall preclude approval for payment for lung transplantation:
   1. Active infection.
   2. Acute severe hemodynamic compromise at the time of transplantation, if accompanied by significant compromise of one or more non-pulmonary vital end-organs.
   3. Active substance abuse.
   4. Presence of systemic dysfunction or malignant disease which could limit survival, interfere with compliance with a disciplined medical regimen or rehabilitation after transplantation.
   5. Morbid obesity.
   6. Human Immunodeficiency Virus (HIV) antibody positive.

7. Neuropsychiatric disorder which could lead to non-compliance or inhibit rehabilitation for the patient.
8. Cancer, unless treated and eradicated for two or more years or unless a current medical literature review, completed by the transplant center staff and submitted to the Department for staff review and evaluation, documents a greater than or equal to 75% one-year survival rate after transplantation for the age group, specific cancer, diagnosis(es), condition and type of transplantation proposed for the client. The Department shall use independent research by staff medical consultants to evaluate the documentation submitted by the transplant center.
9. Cardiovascular diseases:
    a. Myocardial infarction within six months;
    b. Intractable cardiac arrhythmias;
    c. Class III or IV cardiac dysfunction by New York Heart Association criteria.
    d. Prior congestive heart failure, unless a cardiovascular consultant determines adequate cardiac reserve.
    e. Symptomatic or occlusive peripheral vascular or cerebrovascular disease;
    f. Severe generalized arteriosclerosis.
10. Evidence of other major organ system disease or anomaly which could decrease the probability of successful clinical outcome or decrease the potential for rehabilitation.
11. Behavior pattern documented in the client's medical or psycho-social assessment which could interfere with a disciplined medical regimen. An indication of non-compliance by the client is documented by any of the following:
    a. Non-compliance with medications or therapy.
    b. Failure to keep scheduled appointments.
    c. Leaving the hospital against medical advice.
    d. Active substance abuse.
12. Prior to approval of the transplantation, the transplantation team must document a plan of care, agreed to by the parent(s) or guardian(s), if an indication of non-compliance is demonstrated by the parent(s) or guardian(s) of a client who is under 18 years of age. An indication of non-compliance by the parent(s) or guardian(s) is documented by any of the behaviors listed in section D 11, a through d.

Criteria #30 (Neonatal Care)

Effective June 1, 1999 CPT code 99436, Attendance at Delivery, became available for use by board certified neonatologists and board certified pediatricians in urban or rural areas. Family practice physicians **trained** in neonatal care who practice in rural areas will be recognized and included for reimbursement.***** This code can be used when a high risk delivery is expected, Neonatal Risk Factor Classification Levels three or four are met, and stabilization of the newborn is anticipated. The delivering physician must request the attendance of a qualified neonatologist, pediatrician or family practitioner at the high risk delivery. When resuscitation is required, CPT code 99440 would be used in place of 99436. The two codes can not be used together.

***** The American Academy of Pediatrics recognizes primary care pediatrician and neonatologist expertise in neonatal resuscitation and intubation. The American Academy of Family Practice Physicians and the American College of Obstetricians and Gynecologists have a joint policy statement which requires physicians attending delivery to maintain neonatal resuscitation skills.

Fetal/Neonatal Risk factors are outlined below:

Class I (Attendance at delivery rarely required)

- Vaginal vertex or C-Section at term birth with no identified fetal risk factors
- Term delivery: prolonged labor>24 hours or ROM> 18 hours without fetal distress/amnionitis
- Labor post term>42 weeks without fetal distress
- Non insulin dependent diabetes without fetal distress

Class II (Attendance at delivery may be necessary)

- Meconium staining with no other risk factors
- Term vaginal breech birth or premature labor at 35-36 weeks
- Maternal drug/alcohol abuse, maternal medication, severe preeclampsia, Rh-sensitized mother or maternal disease that may affect the mother
- Term Twins born vaginally or by C-Section with no fetal distress

Class III (Attendance at delivery necessary)

- Meconium staining with any other risk factor
- Significant vaginal bleeding or prolapsed cord or compressed cord
- Signs of fetal distress: persistent late decelerations, prolonged variable decelerations with slow recovery, loss of beat to beat variability >30 minutes, persistent fetal tachycardia (HR >170 for 30 minutes), fetal scalp pH < 7.2, prolonged bradycardia (HR> 80)
- Indicators of lung immaturity: L/S< 2 (surfactant), PG negative, FSI< 0.47, FPOL
- A previous infant with RDS near term
- Complicated multiple gestation < 36 weeks
- Deviation in neonatal size from expected developmental stage, weight <2500 gm. or >4000 gm.
- Ultrasound or amniocentesis identified fetal anomaly, low biophysical ultra sound profile, or high/low alpha-fetoprotein in maternal blood
- Olighydramnios or polyhydramnios except in an infant of a mother with diabetes
- Insulin dependent diabetes
- Premature labor <34 weeks or prolonged 2nd stage of labor > 2 hours
- Chorioamnionitis or known group B streptococcus or serious maternal infection
- Erythroblastosis

Class IV

- Massive vaginal bleeding
- Prolonged amniotic leak > 30 days with oligohydramnios (pulmonary hypoplasia suspected)
- Prematurity: Single fetus < 28 weeks, Twins < 30 weeks, triplets or more < 34 weeks
- Hydrops (any etiology)
- Major fetal anomalies diagnosed antenataly or anticipated eaxtraordinarily ill newborn

Board certified neonatologists, board certified pediatricians, and family practice physicians practicing in rural areas are responsible for maintaining neonatal resuscitation skills.

Criteria #31 (Intestinal Transplantation)

Intestinal transplantation services may be provided for a Medicaid eligible client of any age who meets the following criteria.

A. The client for intestinal transplantation must meet requirements of either item 1 or 2 below:
   1. The client must have irreversible, progressive small bowel and large bowel disease, with a life expectancy of one year or less without transplantation, or must have more than a five-year increase in life expectance with transplantation, with no other reasonable medical or surgical alternative to transplantation available.
   2. The client must have short bowel syndrome that requires daily hyperalimentation with no other reasonable medical or surgical alternative to transplantation available.

B. In addition to meeting one of the requirements listed above in items 1 and 2, the client must meet all of the following requirements:
   1. The transplant center staff must complete, and submit to the Department for staff review and evaluation, a current medical literature review documenting a probability of a successful clinical outcome by having a greater than or equal to 75 percent one-year small bowel graft function rates for patients receiving intestinal transplantation for the age group, specific diagnosis(es), condition, and type of transplantation proposed for the client.
   2. The transplant center staff must complete, and submit to the Department for staff review and evaluation, a current medical literature review documenting a probability of a successful clinical outcome by having a greater than or equal to 85 percent one-year survival rates for patients receiving intestine transplantation for the age group, specific diagnosis(es), condition, and type of transplantation proposed for the client.
   3. Medical assessment that the client is likely to tolerate immunosuppressive therapy and a reasonable risk for surgery.
   4. Medical assessment by the clients's referring physician that the client has sufficient mental, emotional, and social stability and support to ensure that the client and parent(s) or guardian(s) will strictly adhere to the long term follow up and the immunosuppressive program which is required.
   5. Psycho-social assessment by a board-certified or board-eligible psychiatrist that the client has sufficient mental, emotional, and social stability and support to ensure that the client and parent(s) or guardian(s) will strictly adhere to the long term follow up and immunosuppressive program which is required.
   6. The client must have strong motivation to undergo the procedure as documented by the medical and psycho-social assessment.
   7. If the client has a history of substance abuse, then he must successfully complete a substance rehabilitation program or must have documented abstinence for a period of at least six months before the Department reviews a request for transplantation services.
   8. A current medical literature review, completed by the transplant center staff and submitted to the Department for staff review and evaluation, documenting that the underlying original intestinal disease will not recur and limit graft function survival to less than a 75% one-year survival rate.
   9. The Department will use independent research by medical staff consultants to evaluate the documentation submitted by the transplant center.

C. Any single contraindication listed below shall preclude approval for Medicaid payment for small bowel transplantation:
   1. Active infection
   2. Acute severe hemodynamic compromise at the time of transplantation, if accompanied by significant compromise in one or more vital end-organs.
   3. Active substance abuse
   4. Presence of systemic dysfunction or malignant disease which could limit survival, interfere with compliance with a disciplined medical regimen or rehabilitation after transplantation

5. Human Immunodeficiency Virus (HIV) antibody positive.
6. Neuropsychiatric disorder which could lead to non-compliance or inhibit rehabilitation of the patient.
7. Pulmonary diseases
8. Cystic fibrosis
9. Obstructive pulmonary disease (FEV1 less than 50% of predicted)
10. Restrictive pulmonary disease (FVC less than 50% of predicted)
11. Unresolved pulmonary roentgenographic abnormalities of unclear etiology
12. Recent or unresolved pulmonary infarction
13. Cancer, unless treated and eradicated for two or more years, or unless a current medical literature review, compiled by the transplant center documents a one year transplant survival rate greater than or equal to 85% for the age group, specific cancer, diagnosis (es), condition, and type of transplantation proposed for the client.
14. Cardiovascular diseases
15. Myocardial infarction within six months
16. Intractable cardiac arrythmias
17. Class III or IV cardiac dysfunction by the New York Heart Association criteria
18. Prior congestive heart failure, unless a cardiovascular consultant determines cardiac reserves are adequate.
19. Symptomatic or occlusive peripheral vascular or cerebrovascular disease
20. Severe generalized arteriosclerosis
21. Evidence of other major organ system disease or anomaly which could decrease the probability of successful clinical outcome or decrease the potential for rehabilitation.
22. Behavior pattern documented in the client's medical or psycho social assessment which could interfere with a disciplined medical regimen. An indication of noncompliance by the client is documented by any of the following:
    a. Non-compliance with medications or therapy
    b. Failure to keep scheduled appointments
    c. Leaving the hospital against medical advice
    d. Active substance abuse

D. Non-compliance is demonstrated by documentation of any of the behaviors listed in item 22. Prior to approval of the transplantation, the transplant team must document a plan of care agreed upon with the parent(s) or guardian(s) where non-compliance is an issue in a client who is under 18 years of age

Criteria #32: Neurostimulators

Criteria #32 A: Neurostimulators for Epilepsy

Coverage will apply only to partial (focal) onset seizures that are clinically recognizable. Vagal nerve neurostimulators (VNS) are not covered for generalized seizures.

A. As required in FDA approval, VNS recipients must be older than twelve years of age. The patient's seizures must have been refractory to multiple drugs. This includes conventional and newer anticonvulsant drugs given as add on treatments.

B. The patient must have been experiencing at least four to six identifiable partial onset seizures each month. Intractable epilepsy is defined as at least one seizure per month. The patient must have a diagnosis of intractable epilepsy for at least two years.

C. VNS recipients must not be candidates for epilepsy surgery.

D. Recipients may not have a progressive disorder such as a progressive metabolic or degenerative disorder or a malignant brain lesion.

E. The patient must have been evaluated by a neurologist.

   1. The neurologist is able to diagnose nonepileptic seizures and behavioral aberrations. These conditions will not be recognized as a seizure.

   2. Since there are potentially serious cardiovascular and respiratory effects related to the device, the patient should be evaluated by the neurologist to determine if the patient has other serious neurological or medical conditions which may make the patient ineligible for the procedure.

   3. The patient must have undergone quality of life measurements. The neurologist recommending VNS must stipulate in the records that VNS placement, in their expert opinion, will reduce seizure frequency and improve the quality of life for the patient.

   4. Submitted documentation should describe how the diagnosis of partial onset epilepsy was established, including clinical, physiological, and/or imaging reports. It should also include how intractability and refractoriness to medical treatment was determined.

G. The procedure must be performed by the neurologist or a surgeon who has completed Vagal Neurostimulator (VNS) training.

H. The patient, and/or person responsible for the patient, should be informed of the benefits and risks of the surgery, including the experience of the medical center and performing surgeon.

I. The following ICD9 codes support medical necessity:

   345.41 Partial epilepsy, with impairment of consciousness, intractable

   345.51 Partial epilepsy, without mention of impairment of consciousness, intractable

Criteria #32 B: Sacral Nerve Stimulation

The sacral nerve stimulator helps to control bladder contractions. It has shown effectiveness for patients with disabling urge incontinence. The sacral nerve stimulator for urinary incontinence is a two step process. The initial percutaneous sacral nerve stimulator is implanted usually for a 5 to 14 day trial period to ensure the patient is able to handle the device and evaluate how effectively the device functions for them. The permanent device is not considered for implantation until evaluation of percutaneous placement indicates beneficial function. A patient eligible for the percutaneous device must meet the following criteria:

A. Symptoms of disabling urge incontinence must have been present for at least one year or more. The urge incontinence is considered disabling only when the frequency and severity of leakages limits the patient's ability to work or participate in activities outside of the home.

B. All reasonable conservative treatments must have been tried and been proven unsuccessful. Conservative medical treatments include behavioral techniques such as bladder training, prompted voiding, pelvic muscle exercise training, fluid management and pharmacotherapies which must include at least two anticholinergic drugs or a combination of a tricyclic antidepressant and anticholinergic drugs.

C. The prescribing physician must be experienced in the diagnosis and treatment of lower urinary tract disorders such as a urologist. The physician implanting the device must be a urologist or neurosurgeon who has had specialized training in the sacral neurostimulator. Submitted medical record documentation must support the diagnosis of disabling urge incontinence (788.31) and indicate all possible conservative medical treatments have failed.

D. The patient must be an appropriate surgical candidate such that implantation with anesthesia can occur. The patient must be able to operate the neurostimulator.and demonstrate the ability to maintain a daily voiding record so that the clinical results of the percutaneous implant procedure can be evaluated.

Limitations

A. Current research does not support the use of the device for stress incontinence, urinary retention, mechanical obstructions such as benign prostatic hypertrophy, cancer, or urethral stricture, or specific neurological diseases (i.e. diabetes with peripheral nerve involvement).

B. During the 5 to 14 day trial period with the percutaneous sacral nerve stimulator period, the device is evaluated for effectiveness in diminishing urge incontinence. The patient must have demonstrated the ability to operate the neurostimulator and have the appropriate physical response. For approval of permanent sacral neurostimulator placement, the test of the percutaneous device must have provided at least a 50% decrease in incontinence symptoms.

Criteria #32 C: Spinal Cord Nerve Stimulation (codes 63650, 63655)

The spinal cord nerve stimulator serves to block conduction pathways and stimulate endorphins. The electrodes used for this purpose may be implanted percutaneously in the epidural space (63650) or laminectomy (63655) may be required to place the electrodes. It has shown effectiveness for patients with intractable chronic pain caused by nerve root injuries, incomplete spinal injury and is sometimes used to treat intractable angina. The initial percutaneous spinal cord nerve stimulator is implanted usually for a four-week trial period to ensure the patient tolerates the device and assess whether the modality is effective. The permanent device is not considered for implantation until evaluation of percutaneous placement demonstrates beneficial function. Patients eligible for the percutaneous device must meet the following criteria:

A. Indications:

1. It is to be used as a last resort for intractable non-malignant pain wherein other treatment modalities (pharmacological, surgical, physical , and/or psychological therapies) have been tried and failed.

2. It may be covered for non malignant pain only when all of the following conditions are met:
   a. The patient has under gone a psychological evaluation which indicates they are a suitable candidate for the device.
   b. The patient is not a candidate for further surgical intervention.
   c. The patient does not have any untreated existing drug habituation.
   d. The patient has predominately radiating extremity pain.
   e. There is documented pathology that supports the complaint of pain. For example:
      (1) There are symptoms of chronic pain by lumbosacral arachnoiditis that has not responded to medical management including physical therapy. The presence of arachnoiditis must be documented by the presence of high levels of proteins in the CSF and/or myelography or MRI.
      (2) Intractable pain caused by nerve root injuries (post-traumatic or post-surgical) including failed back syndrome, intractable cauda equina injury, intractable pain caused by incomplete spinal injury, or intractable pain caused by end stage peripheral vascular disease when the patient cannot undergo revascularization or vascularization failed to relieve pain and it has not responded to medical management.

3. It may be covered for the management of intractable angina in patients who are not surgical candidates and whose pain is unresponsive to all standard therapies when all of the following criteria are met:
   a. The angiography documents significant coronary artery disease and the patient is not a candidate for PTCA or CABG..
   b. The patient's angina pectoris is New York Heart Association Functional Class III (patients are comfortable at rest, less than ordinary physical activity causes fatigue, palpitations, dyspnea, or anginal pain) or Class IV (symptoms of cardiac insufficiency or angina are present at rest; symptoms increase with physical activity).
   c. Reversible ischemia is documented by symptom-limited treadmill exercise test.
   d. The patient has had optimal pharmacotherapy for at least one month. Optimal pharmacotherapy includes the maximum tolerated does of at least two of the following medications: long-acting nitrates, beta-adrenergic blockers, or calcium channel antagoinists.

B. Limitations

1. Current research does not support the use of the device for chronic pain related to malignancy.

2. The device cannot be used for treatment of angina if the patient has had an MI or unstable angina within the previous three months or if significant valve abnormalities have been found by echocardiography.

3. The patient must be an appropriate surgical candidate such that implantation with anesthesia can occur. The patient must be able to operate and tolerate the neurostimulator. There cannot be somatic disorders of the spine that lead to insurmountable technical problems in treatment with a spinal cord stimulator.

4. During the seven to 30-day trial period with the percutaneous sacral nerve stimulator period, the device is evaluated for effectiveness in diminishing pain. The patient must have demonstrated the ability to operate the neurostimulator and have the appropriate physical response. For approval of permanent spinal cord neurostimulator placement, the test of the percutaneous device must have provided at least a 50% decrease in pain reduction over at least a seven day trial period.

C. The following ICD.9 codes support medical necessity.

337.21 Reflex sympathetic dystrophy of upper limb
337.22 Reflex sympathetic dystrophy of the lower limb
337.29 Reflex sympathetic dystrophy of other unspecified site
353.0 Brachial plexus lesions
353.1 Lumbosacral plexus lesions
353.8 Nerve root and plexus disorders, other
413.9 Other angina pectoris (excludes preinfarction angina)
440.22 Atherosclerosis of extremities at rest
443.9 Peripheral vascular disease, unspecified
722.81 Postlaminectomy syndrome Cervical region
722.82 Postlaminectomy syndrome Thoracic region
722.83 Postlaminectomy syndrome Lumbar region
952.4 Cauda equina injury
953.0 Injury to cervical nerve root
953.1 Injury to dorsal nerve root
953.2 Injury to lumbar nerve root
953.3 Injury to sacral nerve root

Criteria #33A: Trigger Point Injections

According to Medicare, myofascial trigger points are self-sustaining hyperactive foci that may occur in any skeletal muscle in response to strain from acute or chronic overload. These trigger points produce a referred pain typical for the particular muscle group. Injection is achieved with needle insertion and the administration of a local anesthetic such as Lidocaine. Conservative therapy including analgesics, physical therapy exercises, range of motion exercises, bed rest, heating or cooling modalities, massage, and pharmacotherapies such as muscle relaxants, non-steroidal anti-inflammatory agents and non-narcotic analgesics often resolves the myofascial pain syndrome.

Limitations

1. Trigger points must be identifiable on palpation and the symptoms must have persisted for at least three months. Conservative medical treatments must have been tried and failed. Trigger injections may be indicated when noninvasive conservative medical management is unsuccessful or when the joint movement is mechanically blocked (i.e., coccygeus muscle – pelvis). Acupuncture remains strictly a non-covered service even for trigger points.

2. The medical record must describe the assessment and evaluation which led to a diagnosis related to the need for a trigger point injection. The conservative treatment options which were provided should include outcome specifics. Documentation of trigger point follow-up care, such as cold packs, massage, and muscle stretching exercises, should indicate a minimum of at least three days of therapy. The patient should be taught massage, appropriate use of heat or cold therapy, and muscle stretching exercises to continue long term, so that the myofascial pain syndrome does not return.

3. Payment for trigger point injections, code 20552, is limited to one per day regardless of the number of injections administered. Note that no more than three injections should be provided on a single date.

4. Trigger point injections must be at least two weeks apart.

5. Coverage for trigger point injections is limited to 8 billed charges per year.

6. Nerve block injection codes 64400-64530, code **20610**, and code 10160 will not be paid on the same date of service.

7. Code 20552 is not covered for generalized diagnoses such as low back pain, myalgia, or lumbago. A precise diagnosis must be used. The following list describes the only diagnosis codes that will be recognized for payment:

355.6	Mortons neuroma
720.1	Spinal enthesopathy
723.9	Unspecified musculoskeletal symptoms referable to neck
726.0	Adhesive capsulitis of shoulder
726.01-19	Rotator cuff syndrome
726.2	Shoulder region other
726.3-39	Enthesopathy of elbow region
726.4	Enthesopathy of wrist and carpus
726.5	Enthesopathy of hip region
726.6-69	Enthesopathy of knee
726.90	Unspecified enthesopathy (rectus femoris, vastus intermedius, vastus medial-anterior and posterior, biceps femoral)
726.71	Achilles bursitis or tendinitis (soleus, gastrocnemius)
726.72	Tibialis tendinitis (tibialis anterior)
726.79	Other enthesopathy of ankle and tarsus (peroneus longus and brevis, extensor digitorum, hallucis longus, third dorsal interosseous)
727.40	Synovial cyst, unspecified
727.41	Ganglion of joint
727.42	Ganglion of tendon sheath
843.0-843.8	Sprains and strains of hip and thigh
846.0-846.8	Sprains and strains of sacroiliac region
847.0-847.8	Sprains and strains of back

Criteria #33B: Epidural and Nerve Blocks

There are three types of injections. Steroids are given to reduce inflammation as treatment for chronic radiculopathy caused by nerve root irritation or pressure (i.e. spinal stenosis) when conservative medical treatments have failed. Anesthetic or narcotic injections are injected into the epidural space to achieve a sympathetic block for the diagnosis and treatment of reflex sympathetic dystrophy and para vertebral blocks are used when the patient has localized pain that is aggravated by motion of the spine without a strong radicular component or associated neurologic deficit. Epidural and nerve blocks injections are not intended for long-term or ongoing pain management.

Coverage

1. Medical record documentation must support the medical necessity of the procedure and the conservative measures that have been tried and failed. The documentation should include documentation of the symptoms supporting the complaint of pain and the efficacy of the nerve block or epidural for treating the pain described including the anatomical relationship of the injection to the pain treatment.

2. Medical record documentation must indicate that patient has tried and failed to improve after **at least six** weeks of conservative measures such as rest, systemic analgesics and/or PT. Non drug therapies should be considered, including electrical stimulation, counter irritation, trigger point injection, spray and stretch, massage, and physical therapy. Cognitive techniques of pain control (i.e., relaxation training, distraction techniques, hypnosis, biofeedback) may be useful.

3. Epidural injection or nerve blocks should not be considered until the patient has been evaluated for a pathological cause of pain such as a tumor or cancer.

4. Only one of the following injection types will be covered on a date of service.
   A. Facet joint injections:
      (1) Facet joint pain is generally suspected in patients with neck and/or back pain that may or may not have a radicular component. Focal tenderness is usually present over the facet joint and aggravated by rotation or hyper extension of the spine. Facet joint injections are appropriate for the management of chronic back pain when pain has lasted more than three months despite appropriate conservative medical therapy. The injections must be used in conjunction with other noninvasive treatment methods, not as a standard therapy alone. (AHCPR position paper)
      (2) A diagnostic or therapeutic facet joint nerve block (64470-64476) must have demonstrated that the patient received significant temporary or prolonged abolition of the pain.
   B. Sacroiliac Joint injections:
      (1) Injections covered in patients who have had back pain greater than three month
      (2) The injections must be used in conjunction with other noninvasive treatment techniques, not as stand alone therapy.
   C. Epidural injections of corticosteroid medications with or without anesthetic agents are covered only when the pain is not spinal in origin (spinal tumor or lesion) and the patient has failed to improve after six weeks of conservative therapies.

Limitations

1. Low back pain radiating to the legs may be myofascial pain syndrome. Since nerve root pathology is not present with this syndrome, epidural injections are not covered.

2. There is no separate payment for injecting the contrast material into the epidural space to confirm needle placement for pain management procedures.

3. The CPT codes pertain to injection services. Non-invasive neuron blockade methods such as electroceutical neuron blockade devices are not covered.

4. Limitations of coverage by injection type:
   A. Facet joint injections: When effectiveness has been demonstrated, injections will be covered up to a maximum of three sets of injections per calendar year. One set is defined as a maximum of three anatomical sites at one session such as different levels or different sides. If greater than three sets are required by the patient, the procedure is ineffective or there is an underlying condition that requires further evaluation and treatment.
   B. Sacroiliac injections are limited to three injections over a calendar year.
   C. Epidural: Injections are limited to three per calendar year. No more than three facet injections will be paid on a single date of service. Trigger point injections and blocks are not covered on the same date of service. When a set of facet joint blocks **(3)** is provided, additional injections such as epidural, bilateral sacroiliac joint injections, and sympathetic blocks are generally not necessary. Therefore, these injections will not covered on the same date of service.

5. If it is believed more than three injections are medically necessary, prior authorization will be required. Documentation should include the clinical evidence in support of multiple injections for the condition under treatment and the anatomical relationship of the injections to the pain treatment.

6. Claims related to pain management will be reviewed periodically and are subject to post payment review. The following codes will be evaluated related to this policy:

   20610 major joint or bursa; sacroiliac joint injection

   62310, 62311 Injection DX or Rx substance (anesthetic) epidural or subarachnoid . . .

   62318, 62319 injection/cath placement for drug infusion epidural or subarachnoid . . .

   64405, 64418, 64420, 64421, 64435, 64470, 64472, 64475, 64476, 64479, 64480, 64483, 64484, 64510, 64520, 64530: anesthetic injection . . .

Criteria #34: Removal of Benign or Premalignant Skin Lesions

Benign or premalignant skin lesions skin lesions are covered by Medicaid only when the following indications documented in the medical record indicate the lesion removal is medically necessary and not cosmetic.

1. The lesion is in anatomical area subject to recurrent physical trauma, and there is documentation that such trauma has in fact repeatedly occurred or the lesion obstructs an orifice or clinically restricts vision.

2. A prior biopsy suggests or is indicative of lesion malignancy, or based on the lesion's appearance, such as recent changes in color or enlargement, malignancy is a realistic consideration.

3. Lesions which may be considered for coverage may include those which bleed, itches intensely and/or are painful.

4. To consider removal of a benign lesion not cosmetic, medical records maintained by the physician must clearly document the medical necessity for lesion removal.

5. Codes will be considered for coverage only when the diagnosis code is listed in the group below. However, benign or premalignant skin lesions must also meet the requirements stated under **Limitations** (which follows the list of ICD-9 codes below).
   - 078.0 Molluscum contagiosum
   - 078.10 Viral warts, unspecified
   - 078.11 Condyloma acuminatum
   - 078.19 Other specified viral warts
   - 171.0 Malignant neoplasm of connective and other soft tissue, head, face and neck
   - 173.0 Other malignant neoplasm of skin of lip
   - 173.2 Other malignant neoplasm of skin, ear and external auditory canal
   - 173.3 Other malignant neoplasm of skin, unspecified parts of face
   - 173.4 Other malignant neoplasm of skin, scalp and skin of neck
   - 173.5 Other malignant neoplasm of skin, skin of truck, except scrotum
   - 173.6 Other malignant neoplasm of skin, upper limb, including shoulder
   - 173.7 Other malignant neoplasm of skin, lower limb, including shoulder
   - 173.8 Other malignant neoplasm of skin, other specified sites of skin
   - 173.9 Other malignant neoplasm of skin, unspecified
   - 216.0 Benign neoplasm of skin of lip
   - 216.1 Benign neoplasm of eyelid, including canthus
   - 216.2 Benign neoplasm of skin of ear and external auditory canal
   - 232.0 Carcinoma in situ of skin of lip
   - 232.1 Carcinoma in situ of eyelid, including canthus
   - 232.2 Carcinoma in situ of ear and external auditory canal
   - 232.3 Carcinoma in situ of skin of other and unspecified parts of face
   - 232.4 Carcinoma in situ of scalp and skin of neck
   - 232.5 Carcinoma in situ of skin of trunk except scrotum
   - 232.6 Carcinoma in situ of upper limb including shoulder
   - 232.7 Carcinoma in situ of lower limb, including hip
   - 686.1 Pyogenic granuloma of skin and subcutaneous tissue
   - 701.0 Circumscribed scleroderma
   - 701.2 Acquired acanthosis nigricans
   - 707.10 Ulcer of lower limb, except decubitus ulcer, unspecified
   - 707.11 Ulcer of thigh
   - 707.12 Ulcer of calf
   - 707.13 Ulcer of ankle
   - 707.14 Ulcer of heel and midfoot
   - 707.15 Ulcer of other part of foot
   - 707.19 Ulcer of other part of lower limb
   - 707.8 Chronic ulcer of other specified sites
   - 707.9 Chronic ulcer of unspecified site
   - 919.7 Superficial foreign body (splinter) of other, multiple, and unspecified sites, without major open wound, infected

Limitations

1. Benign lesions such as seborrheic keratoses, hemangiomas, and sebaceous epidermoid cysts, are not covered.

2. A record statement of “irritated skin lesion” is not sufficient justification for lesion removal when based on the patient’s complaint or the physician’s physical findings. Similarly, use of ICD-9 code 702.11, inflamed seborrheic keratosis, is not sufficient to justify lesion removal without medical record documentation of the patient’s symptoms and physical findings.

3. Removal of benign skin lesions that do not pose a threat to function or health are considered cosmetic and are not covered by Medicaid.

4. Lesions in sensitive anatomic locations that are not problematic do not qualify for removal coverage based on location alone.

5. Benign lesion excision, codes 11300-11313, 11400 - 11446 and 17000-17110, may be reviewed under this policy. Medical record documentation must support the medical necessity of surgical excision over another removal procedure and support that the removal was not for cosmetic purposes

6. If the physician does not believe that removal of the skin lesion would be covered by Medicaid, or authorization is denied, but the patient wants the lesion removed, the physician must notify the patient that the surgery is not covered. In order for the physician to bill the Medicaid client for a non-covered service, the provider must exactly follow the conditions listed in SECTION 1 of the Utah Medicaid Provider Manual, Chapter 6 - 8, Exceptions to Prohibition on Billing Patients, item 1, Non-Covered Services.

Criteria #35: Corneal Topography

Corneal topographic mapping is a diagnostic procedure used to detect corneal surface irregularities and astigmatism. The procedure involves visualization of the corneal surface. With computer assistance the image is stored, digitalized and developed into a three-dimensional reconstruction of the surface of the cornea. A color-coded map of the corneal surface is produced as well as a cross-section profile. Since the procedure does not have a CPT code, the unlisted code 92499 is used for corneal topography. According to Medicare, services are similar to code 92286. Therefore, reimbursement established for code 92286 will be used for 92499.

Indications for Coverage

1. The procedure may be considered medically necessary when a corneal transplant or retransplant is anticipated, in the diagnosis and management of keratoconus, post operative management of corneal transplants, and management of corneal trauma, dystrophies, and scars.
2. For coverage the patient's condition must meet one of the covered ICD-9 diagnosis' codes in this policy and medical necessity must be clearly documented in the medical record to support testing.
3. Recurrent corneal erosions (371.42) are covered only when medical record documentation indicates conservative measures have been tried and failed to halt erosion such as hypertonic saline, lubricants, patching, and gentle debridement of aberrant epithelium.

Limitations/Non Coverage

1. Medicare and Medicaid do not cover pre- or postoperative corneal topography for non-covered services such as radial keratomy or lasik eye surgery. It is not covered as a screening examination.
2. Corneal topography is considered part of the evaluation and management service of general ophthalmological services 92002 - 92014. When submitted with an E&M ophthalmology service, an incidental edit will post indicating there is no separate reimbursement.
3. Corneal topography will not be paid for preoperative cataracts unless there is medical record documentation of irregular astigmatism. When medical record documentation indicates medical necessity because of high astigmatism after cataract or glaucoma surgery, corneal topography is a covered service.
4. Optical Coherence Tomography (OCT) is an ultrasonic method to evaluate ocular structures through high longitudinal resolution cross sections. This procedure may also be submitted under CPT code 92499. According to Medicare, the OCT procedure is considered investigational and insufficient data exist to support the clinical significant benefit of OCT beyond existing technologies. Therefore, the procedure is not covered by Medicaid.
5. Corneal topography is limited to one service per year with clear documentation of medical necessity.

Covered ICD-9 codes

V42.5 Corneal transplant
V45.2 Presence of cerebrospinal fluid drainage device
367.22 Irregular astigmatism
370.03 Central corneal ulcer
370.07 Mooren's ulcer
370.50 Interstitial keratitis
371.00 Corneal opacity, unspecified includes corneal scar
371.01 Minor corneal opacity, nebula
371.02 Peripheral corneal opacity
371.03 Central cornea opacity
371.04 Adherent leucoma
371.40 Corneal degeneration unspecified
371.42 Recurrent erosion of cornea (*see Coverage section)
371.46 Nodular degeneration of cornea
371.48 Peripheral degenerations of the cornea (Terriens)
371.50-371.58 Hereditary corneal dystrophies
371.60-371.62 Keratoconus
371.70 Corneal deformity unspecified
371.71 Corneal ectasia
372.40-372.45 Pterygium
743.22 Buphthalmos associated with other ocular anomalies
743.41 Anomalies of corneal size and shape
996.51 Mechanical complication due to corneal graft

Criteria #36: Urinalysis, Urine Culture

A urinalysis is the evaluation of urine and urinary sediment preformed for screening purposes or for medically necessary and reasonable indication for medical management of a patient's condition. Urinalysis is covered when there is a documented diagnosis or clinical impression which justifies the test for management of disease. Basic screening tests and expanded cultures performed routinely on all specimens will not be covered.

A. Coverage

1. One urinalysis, when initially caring for women in the antenatal period, is allowed as part of prenatal care. Additional testing requires documentation of medical necessity.
2. Two services during a 30-day period for the diagnosis of urinary tract infection are allowed. More frequent service requires additional documentation for the medical record.
3. When the chemical analysis is sufficient to diagnose or treat the patient, and a microscopic evaluation would provide no additional information needed for decision making, the microscopic examination will be denied. The need for microscopic examination must be present by inference from the patient's condition.
4. Urine culture must be justified as medically necessary in the medical record.
    a. Patients' urinalysis is abnormal suggesting urinary tract infection (UTI). A urine culture is not always needed for female patients presenting with acute onset symptoms of cystitis and abnormal urinalyses. These patients usually respond to presumptive antimicrobial therapy. Non responders or those patients who relapse after therapy should have a definitive urine culture with sensitivity.
    b. Patient has clinical symptoms indicative of a possible UTI.
    c. A urine culture is being done to follow up on a previously treated UTI to confirm effectiveness of therapy.
    d. Follow up cultures within a week or two of therapy may be indicated for patients who have complicated infections (urinary tract abnormality, foreign body) or who are known to be at risk for relapse.
    e. Patient is being evaluated for fever of unknown origin or suspected septicemia.
    f. Patients with indwelling urinary catheters are not usually candidates for urinary cultures unless the culture is done in anticipation of catheter removal or the patient becomes symptomatic and treatment is contemplated.

B. Coding and Documentation

1. When billing for urinalysis and urine cultures, coding should not be fragmented if a single test will provide the necessary information.
    a. Only one test is allowed on the same day unless documentation supports the medical reasonableness and necessity for additional testing or cultures.
    b. As per HCFA guidelines, urinalyses by reagent strip (81002 + 81003) are not separately payable from an office visit or consult.
    c. Codes 87086 or 87088 are the usual urine culture codes submitted.
2. ICD9 codes supporting the reasonableness and necessity of this test must be submitted with each claim. Claims without such evidence will be denied as not reasonable and necessary.

ICD9 codes supporting medical necessity

038.0 - 038.9, septicemia
584.5 - 584.9, acute renal failure
590.0 - 590.9, infection of the kidney
595.0 - 595.9, cystitis
597.0 - 597.89, urethritis, not sexually transmitted, and urethral syndrome
598.0, urethral stricture due to infection
599.0, urinary tract infection, site not specified, pyuria
599.7, hematuria
601.0, acute prostatitis
601.3, prostatocystitis
601.9, prostatitis, unspecified
646.63, infections of the genitourinary tract in pregnancy
780.6, fever
785.59, shock, endotoxic, gram negative, septic
788.0 - 788.9, symptoms involving urinary system (hesitancy, burning, frequency)
790.7, bacteremia
791.7, other cells and casts in urine
791.9, other findings on urine examination, nitrite positive, leucocyte esterase positive
939.0 - 939.9, foreign body in genitourinary tract
996.81, complications of transplant, kidney

Criteria #37: Helicobacter Pylori

Helicobacter pylori, a gram negative rod, may be identified in 80 - 95% of patients with duodenal ulcers and 70 - 90% of patients with gastric ulcers. Eradication of H. pylori with antibiotic combinations, bismuth compounds, and acid suppression therapy has become a treatment strategy for ulcers. Many patients with h.pylori have non ulcer dyspepsia. Invasive detection of h.pylori involves endoscopy and culture with either direct histologic identification of the organism or detection of the organism using the CLO (campylobacter-like-organism) test.

A. Coverage

1. Serologic test code 86677, Helicobacter pylori, antibody may indicate either past or present infection. Serologic testing for Helicobacter pylori is appropriate in the initial work-up of the symptomatic patient with a documented history of chronic/recurrent duodenal ulcer, gastric ulcer, or chronic gastritis. Research indicates serologic H.pylori antibody testing in children under ten is an inaccurate test.
2. The stool antigen test 87338 may be recommended for patients who do not respond to therapy or those who have a history of ulcer complications or cancer.
3. Unresponsive dyspepsia or if associated with anemia, indications of GI bleed, anorexia, unexplained weight loss should be investigated with appropriate endoscopy/barium studies and biopsy with culture. The gold standard for diagnosis of active Helicobacter pylori infection in these patients is performance of endoscopy with biopsy and culture. Typically culturing is completed using code 87081, culture presumptive pathogen.

B. Limitations

1. Testing for eradication of H.pylori in patients whose symptoms have resolved is not necessary.
2. Testing is not indicated for new onset dyspepsia responsive to conservative treatment (i.e. withdrawal of non steroidal anti-inflammatory drugs and/or use of antisecretory agents.)
3. Serologic testing for H. pylori is of no clinical value in a dyspeptic patient who requires upper GI endoscopy or patients with documented normal upper GI endoscopy.
4. Serologic testing is of limited value in monitoring response to treatment of H.pylori infection, because titers diminish slowly and the magnitude of decline is variable.
5. Expected laboratory tests for Helicobacter pylori include 86677, 87338, 87081 and surgical pathology evaluations (i.e. 88304-88306) of biopsied specimens. When ICD9 diagnosis supporting medical necessity for helicobacter pylori testing appear with laboratory tests such as 86318-immunoassay for infectious agent antibody which are not specific for helicobacter pylori a diagnosis to procedure denial will occur.
6. Helicobacter pylori breath tests (78267, 78268, 83013, 83014, 83019) and antigen blood test (87339) are not covered services.

ICD 9 codes that support medical necessity

041.86, helicobacter pylori infection
531.0 - 531.91, gastric ulcer
532.0 - 532.91, duodenal ulcer
533.0 - 533.91, peptic ulcer
534.0 - 534.91, gastrojejunal ulcer
535.0 - 535.11, gastritis with or without hemorrhage
535.21, gastric mucosal hypertrophies with hemorrhage
535.40 - 535.41, other specified gastritis with or without hemorrhage
535.50 - 535.51, unspecified gastritis and gastroduodenitis with or without hemorrhage
535.60 - 535.61, duodenitis with or without hemorrhage
536.8, dyspepsia (if chronic or complicated)
558.9, noninfectious gastroenteritis
578.0 - 578.9, gastrointestinal hemorrhage
789.01 - 789.02, abdominal pain, upper right or left quadrant
789.06, abdominal pain, epigastric

ALPHABETICAL INDEX OF CRITERIA

Abdominal Hysterectomy: Criteria #14 . . . 9
Abortion: Criteria #17 . . . 10, 11
Amputation of Penis: Criteria #9 . . . 6
Arthroscopy: Criteria #4 . . . 5
Aspiration procedure, percutaneous, of nucleus pulposus: Criteria #3 . . . 4
Bone Marrow Transplants: Criteria #25 . . . 16
Carpal Tunnel: Criteria #18 . . . 12
Chemonucleolysis, injection procedure: Criteria #3 . . . 4
Contact Lens/Vision Aids: Criteria #20 . . . 12
Cornea Transplants: Criteria #27 . . . 19
Corneal Topography, Corneal topographic mapping: Criteria #35 . . . 36
Diaphragmatic Hernia: Criteria #6 . . . 5
Ectopic Pregnancy: Criteria #16 . . . 10
Emergency Procedures: Criteria #16 . . . 10
Epidural and Nerve Blocks Criteria #33B . . . 33
Epilepsy, Neurostimulators for: Criteria #32 . . . 28
Eye Lid Procedures: Criteria #19 . . . 12
Genito-urinary Procedures: Criteria #10 . . . 7
Gynecological Procedures: Criteria #11 . . . 8
Heart Transplants: Criteria #28 . . . 20
Helicobacter Pylori: Criteria #37 . . . 39
Hernia: Criteria #6, Criteria #7 . . . 5, 6
Hiatal or Diaphragmatic Hernia: Criteria #6 . . . 5
Hyperbaric Oxygen Therapy: Criteria #21 . . . 13
Hysterectomy: Criteria #14 . . . 9, 10
Hysteroscopy: Criteria #13 . . . 8
Inguinal Hernias/orchiectomy: Criteria #7, Criteria #8 . . . 6
Injection procedure of chemonucleolysis: Criteria #3 . . . 4
Intestinal Transplantation: Criteria #31 . . . 26
Kidney Transplants: Criteria #26 . . . 18
Laminectomy: Criteria # 1 . . . 3
Laparoscopy: Criteria #11 . . . 8, 9
Liver Transplants: Criteria #24 . . . 14
Lung Transplants: Criteria #29 . . . 22
Myomectomy: Criteria #12 . . . 8
Neonatal Care: Criteria #30 . . . 24
Nerve Blocks Criteria #33B . . . 33
Neurostimulators: Criteria #32 . . . 28
Neurostimulators for Epilepsy: Criteria #32 . . . 28
Optical Coherence Tomography: Criteria #35 . . . 35
Orchiectomy: Criteria #7, Criteria #8 . . . 6
Removal of Benign or Premalignant Skin Lesions: Criteria #34: . . . 34
Ruptured Uterus: Criteria #16 . . . 10
Sacral Nerve Stimulation: Criteria #32 . . . 29
Septoplasty: Criteria #5 . . . 5
Skin Lesions, Benign or Premalignant, Removal of: Criteria #34: . . . 34
Spine: Criteria #2 . . . 4
Spinal Cord Nerve Stimulation: Criteria #32 C . . . 31
Sterilization/Other Genito-urinary Procedures: Criteria #10 . . . 7
Stimulation, Sacral Nerve: Criteria #32 . . . 29
Surgical Laparoscopy: Criteria #11 . . . 8
Transplants: Criteria #25 - 31 . . . 14, 16, 18-22
Trigger Point Injections: Criteria #33 . . . 32
Urinalysis, Urine Culture: Criteria #36: . . . 38
Vaginal Hysterectomy: Criteria #14, Criteria #15 . . . 10